Complete Summary

GUIDELINE TITLE

Guidelines on bladder cancer: muscle-invasive and metastatic.

BIBLIOGRAPHIC SOURCE(S)

Stenzl A, Cowan NC, De Santis M, Jakse G, Kuczyk M, Merseburger AS, Ribal MJ, Sherif A, Witjes JA. Guidelines on bladder cancer: muscle-invasive and metastatic. Arnhem, The Netherlands: European Association of Urology (EAU); 2008 Mar. 60 p. [366 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Muscle-invasive bladder cancer
- Metastatic bladder cancer

GUIDELINE CATEGORY

Diagnosis
Management
Prevention
Risk Assessment
Treatment

CLINICAL SPECIALTY

Oncology
Surgery
Urology

INTENDED USERS

Nurses
Physicians

GUIDELINE OBJECTIVE(S)

- To help physicians assess the evidence-based management of muscle-invasive and metastatic bladder cancer
- To help physicians incorporate the guideline recommendations into their clinical practice

TARGET POPULATION

Caucasian patients with muscle invasive bladder cancer, urothelial cancer, or transitional cell cancer

INTERVENTIONS AND PRACTICES CONSIDERED

Prevention

1. Smoking cessation (elimination of active and passive smoking)
2. Prevention of occupational exposure to known carcinogens

Diagnosis/Assessment

1. Tumor, node, metastasis (TNM) staging
2. Histologic grading (World Health Organization [WHO] system)
3. Assessment of risk of tumor progression or recurrence (p53 use as a prognostic marker not recommended)
4. Imaging studies: intravenous urography (IVU), computed tomography (CT), ultrasonography (US), contrast-enhanced magnetic resonance imaging (MRI), multidetector-row CT
5. Cytology of voided urine or bladder washings
6. Cystoscopy and fluorescence cystoscopy (using 5-ALA or hexaminolevulinate)
7. Transurethral resection (TUR) or biopsy of bladder and prostatic urethra (male) and bladder neck (female) (under certain circumstances)
8. Second TUR if margins are positive or unclear or there is invasion with no muscle tissue in the sample

Treatment/Management

1. TUR of the bladder tumour (TURBT)
2. Cystectomy (laparoscopic, partial, radical with urinary diversion, neobladder formation)

3. Palliative cystectomy
4. Timing of cystectomy or TURBT
5. Chemotherapy (various single- and multiple agent schedules)
6. Neoadjuvant cisplatin-containing combination chemotherapy
7. Adjuvant chemotherapy if there is remnant disease on imaging or during surgery
8. Treatments to counteract specific chemotherapy toxicities
9. Neoadjuvant external beam radiotherapy
10. Multimodality therapy (TURBT, chemotherapy, and radiotherapy)
11. Quality of life assessments
12. Frequency and type of follow-up

MAJOR OUTCOMES CONSIDERED

- Sensitivity and specificity of diagnostic tests
- Recurrence or progression rate
- Disease-free survival and response rates
- Morbidity and mortality
- Quality of life
- Follow-up

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

General Search Strategy

Up until 2007, the main strategy was to rely on the guidelines group members' knowledge and expertise on the current literature assuming that all, or almost all, relevant information would be captured.

In updates produced from 2008 onwards, a structured literature search will be performed for all guidelines but this search will be limited to randomized controlled trials and meta-analyses, covering at least the past three years, or up until the date of the latest text update if this exceeds the three-year period. Other excellent sources to include are other high-level evidence, Cochrane review and available high-quality guidelines produced by other expert groups or organizations. If there are no high-level data available, the only option is to include lower-level data. The choice of literature will be guided by the expertise and knowledge of the Guidelines Working Group.

Specific Strategy for this Guideline

The recommendations provided in the current guidelines are based on a systemic literature search using Medline, the Cochrane Central Register of Systematic Reviews, and reference lists in publications and review articles.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

1a Evidence obtained from meta-analysis of randomized trials

1b Evidence obtained from at least one randomized trial

2a Evidence obtained from one well-designed controlled study without randomization

2b Evidence obtained from at least one other type of well-designed quasi-experimental study

3 Evidence obtained from well-designed non-experimental studies, such as comparative studies, correlation studies and case reports

4 Evidence obtained from expert committee reports or opinions or clinical experience of respected authorities

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

- The first step in the European Association of Urology (EAU) guidelines procedure is to define the main topic.
- The second step is to establish a working group. The working groups comprise about 4 to 8 members, from several countries. Most of the working group members are academic urologists with a special interest in the topic. Specialists from other medical fields (radiotherapy, oncology, gynaecology, anaesthesiology, etc.) are included as full members of the working groups as needed. In general, general practitioners or patient representatives are not part of the working groups. Each member is appointed for a four-year period, renewable once. A chairman leads each group.
- The third step is to collect and evaluate the underlying evidence from the published literature.
- The fourth step is to structure and present the information. All main recommendations are summarized in boxes and the strength of the recommendation is clearly marked in three grades (A-C), depending on the evidence source upon which the recommendation is based. Every possible effort is made to make the linkage between the level of evidence and grade of recommendation as transparent as possible.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendation

A. Based on clinical studies of good quality and consistency addressing the specific recommendations and including at least one randomized trial
B. Based on well-conducted clinical studies, but without randomized clinical trials
C. Made despite the absence of directly applicable clinical studies of good quality

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The Appraisal of Guidelines for Research and Evaluation (AGREE) instrument was used to analyse and assess a range of specific attributes contributing to the validity of a specific clinical guideline.

The AGREE instrument, to be used by two to four appraisers, was developed by the AGREE collaboration (www.agreecollaboration.org) using referenced sources for the evaluation of specific guidelines. (See the "Availability of Companion Documents" field for further methodology information).

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions for the levels of evidence (1a-4) and grades of recommendation (A-B) are provided at the end of the "Major Recommendations" field.

Epidemiology and Risk Factors

Conclusions

- The incidence of muscle invasive disease has not changed for a period of 5 years.
- Active and passive tobacco smoking continues to be the major risk factor while exposure-related incidence is decreasing (**Level of evidence: 2a**).
- The estimated male to female ratio was 3.8:1, with women more likely to be diagnosed with primary muscle invasive disease than men.
- Currently, treatment decisions cannot be based on molecular markers.

Recommendation

- The most important primary prevention for muscle-invasive bladder cancer is to eliminate active and passive smoking (**Grade of recommendation: B**).

Guidelines on Assessment of Tumour Specimens

Mandatory Evaluations

- Depth of invasion (categories pT2 vs pT3a, pT3b or pT4)
- Margins with special attention paid to the radial margin
- Histological subtype, if it has clinical implications
- Extensive lymph node representation (more than eight)

Optional Evaluations

- Bladder wall blood vessel invasion
- Pattern of muscle invasion

Diagnosis and Staging

Diagnosis

Recommendations for Primary Assessment of Presumably Invasive Bladder Tumours

- Renal and bladder ultrasonography, intravenous urography (IVU) or computed tomography (CT) prior to transurethral resection (TUR) (**Grade of recommendation: B**).
- Cystoscopy with description of the tumour (site, size, number and appearance) and mucosal abnormalities. A bladder diagram is recommended (**Grade of recommendation: C**).
- TUR in one piece for small tumours (less than 1 cm), including a part from the underlying bladder muscle wall (**Grade of recommendation: B**).
- TUR infractions (including muscle tissue) for larger tumours (**Grade of recommendation: B**).

- Biopsies of abnormal-looking urothelium, biopsies from normal-looking mucosa when cytology is positive or when exophytic tumour is of non-papillary appearance or in case of fluorescence if photodynamic diagnosis (PDD) is used (**Grade of recommendation: C**).
- Biopsy of the prostatic urethra in the case of bladder neck tumour, when bladder carcinoma in situ (CIS) is present or suspected or when abnormalities of prostatic urethra are visible (**Grade of recommendation: C**).
- Careful inspection with histological evaluation of the bladder neck and urethral margin, either prior to or at the time of cystoscopy in women undergoing a subsequent orthotopic neobladder (**Grade of recommendation: C**).
- A second TUR at 2 to 6 weeks after the initial resection when it was incomplete or when a high-grade or T1 tumour was detected (**Grade of recommendation: B**).
- The pathological report should specify the grade, the depth of tumour invasion and whether the lamina propria and muscle are present in the specimen (**Grade of recommendation: C**).

Imaging for Staging in Verified Bladder Tumours

Conclusions

- Diagnosis of invasive bladder cancer is made by cystoscopy and biopsy.
- Imaging is used for formal staging only if it will make a difference to the selection of treatment options.
- In all T1 tumours considered for conservative treatment, a second TUR is recommended before deciding on definite treatment (**Grade of recommendation: B**).

Recommendations for Staging

- For optimal local staging, either MRI with fast dynamic contrast-enhancement or MDCT with contrast enhancement are recommended for patients considered suitable for radical treatment (**Grade of recommendation: B**).
- For patients with confirmed muscle-invasive bladder cancer, multidetector-row CT(MDCT) of the chest, abdomen and pelvis is the optimal form of staging, including MDCT urography for complete examination of the upper urinary tracts. If MDCT is not available, lesser alternatives are excretory urography and a chest X-ray (**Grade of recommendation: B**).

Treatment Failure of Non-Muscle-Invasive Bladder Tumours

Recommendations

- In all T1 tumours at high risk of progression (such as high grade, multifocality, CIS present, and tumour size, as outlined in the non-muscle-invasive bladder cancer European Association of Urology [EAU] guideline) (See the National Guideline Clearinghouse [NGC] summary of the EAU Guidelines on TaT1 [non-muscle invasive] bladder cancer) immediate radical cystectomy is an option (**Grade of recommendation: B**).

- In all T1 patients failing intravesical therapy, cystectomy is an option. A delay in cystectomy increases the risk of progression and cancer-specific death (**Grade of recommendation: B**).

Neoadjuvant Chemotherapy

Conclusions

- Neoadjuvant cisplatin-containing combination chemotherapy improves overall survival by 5 to 7% at 5 years (**Level of evidence: 1a**), irrespective of the type of definitive treatment used.
- Neoadjuvant chemotherapy has its limitations regarding patient selection, current development of surgical technique, and current chemotherapy combinations.

Recommendations

- Neoadjuvant cisplatin-containing combination chemotherapy should be considered in muscle-invasive bladder cancer, irrespective of definitive treatment (**Grade of recommendation: A**).
- Neoadjuvant chemotherapy is not recommended in patients with performance status (PS) $\geq$2 and impaired renal function (**Grade of recommendation: B**).

Radical Surgery and Urinary Diversion

Conclusions

- Cystectomy is the preferred curative treatment for localised bladder neoplasm (**Level of evidence: 2**)
- Radical cystectomy includes removal of regional lymph nodes, the extent of which has not been sufficiently defined (**Level of evidence: 3**)
- Radical cystectomy in both sexes must not include the removal of the entire urethra in all cases, which may then serve as outlet for an orthotopic bladder substitution (**Level of evidence: 3**)
- Terminal ileum and colon are the intestinal segments of choice for urinary diversion (**Level of evidence: 3**)
- The type of urinary diversion does not affect oncological outcome (**Level of evidence: 3**)

Recommendations for Radical Cystectomy

- Radical cystectomy in T2-T4a, N0-NX, M0, and high risk non-muscle invasive bladder cancer (BC) (see Treatment Failure of Non-Muscle-Invasive Bladder Tumors, above) (**Grade of recommendation: B**)
- No preoperative radiotherapy (**Grade of recommendation: A**)
- Lymph node dissection should be an integral part of cystectomy, extent not established (**Grade of recommendation: B**)
- Preservation of the urethra is reasonable if margins are negative. If no bladder substitution is attached the urethra must be checked regularly (**Grade of recommendation: B**)

- Laparoscopic and robot assisted laparoscopic cystectomy may be an option. Current data, however, have not sufficiently proven its advantages or disadvantages (**Grade of recommendation: C**).

Recommendations for Urinary Diversion

- Treatment is recommended at centers experienced in major types of diversion techniques and postoperative care (**Grade of recommendation: B**)
- Before cystectomy, the patient should be counselled adequately regarding all possible alternatives, and the final decision should be based on a consensus between patient and surgeon (**Grade of recommendation: B**).
- An orthotopic bladder substitute should be offered to male and female patients lacking any contraindications and who have no tumour in the urethra and at the level of urethral dissection (**Grade of recommendation: B**)

Non-Resectable Tumours

Conclusions

- Primary radical cystectomy in T4b bladder cancer is not a curative option.
- If there are symptoms, radical cystectomy may be a therapeutic/palliative option.
- Intestinal or non-intestinal forms of urinary diversion can be used with or without palliative cystectomy.

Recommendations

- For patients with inoperable locally advanced tumours (T4b), primary radical cystectomy is not a curative option (**Grade of recommendation: B**).
- The indication for performing a palliative cystectomy is symptom relief.
- Morbidity of surgery and quality of life should be weighed against other options (**Level of evidence: 3; Grade of recommendation: B/C**).

Neo-Adjuvant Radiotherapy

Conclusions

- It is not proven that pre-operative radiotherapy for operable muscle-invasive bladder cancer increases survival (**Level of evidence: 2**).
- It is shown that pre-operative radiotherapy for operable muscle-invasive bladder cancer, using a dose of 45 to 50 Gy in fractions of 1.8 to 2 Gy results in down-staging after 4 to 6 weeks (**Level of evidence: 2**).
- Pre-operative radiotherapy with a dose of 45 to 50 Gy/1.8 to 2 Gy does not seem to significantly increase toxicity after surgery (**Level of evidence: 3**).
- There are suggestions in older literature that pre-operative radiotherapy will result in a decrease in local recurrence of muscle-invasive bladder cancer (**Level of evidence: 3**).

Recommendations

- Pre-operative radiotherapy is not recommended to improve survival (**Grade of recommendation: B**).
- Pre-operative radiotherapy for operable muscle-invasive bladder cancer results in tumour downstaging after 4 to 6 weeks (**Grade of recommendation: A-C**).

Bladder-Sparing Treatments

Transurethral Resection

Conclusion and Recommendation

TUR alone is not a curative treatment option in most patients (**Level of evidence: 2a; Grade of recommendation: B**).

External Beam Radiotherapy

Conclusions

- External beam radiotherapy alone should only be considered as a therapeutic option when the patient is unfit for cystectomy or a multimodality bladder-preserving approach (**Level of evidence: 3**).
- Radiotherapy can also be used to stop bleeding from the tumour when local control cannot be achieved by transurethral manipulation because of extensive local tumour growth (**Level of evidence: 3**).

Recommendation

- There is evidence that radiotherapy alone is less effective than curative therapy (surgery or trimodality treatment) (**Grade or recommendation: B**).

Chemotherapy

Conclusion

- With cisplatin-based chemotherapy as primary therapy for locally advanced tumours in highly selected patients, complete and partial local responses have been reported (**Level of evidence: 2b**).

Recommendation

Chemotherapy alone is not recommended as primary therapy for localized bladder cancer (**Grade of recommendation: A**).

Multimodality Treatment

Conclusions

- A multimodality treatment approach shows a long-term survival rate comparable to that of primary treatment with radical cystectomy (**Level of evidence: 3**).
- Delay in surgical therapy can compromise survival rates. (**Level of evidence: 2b**).

Recommendations

- TUR alone is not a curative treatment option in most patients (**Grade of recommendation: B**).
- Radiotherapy alone is less effective than surgery (**Grade of recommendation: B**).
- Chemotherapy alone is not recommended as primary therapy for localized bladder cancer (**Grade of recommendation: B**).
- Multimodality treatment is an alternative in selected, well-informed and compliant patients where cystectomy is not considered for clinical or personal reasons (**Grade of recommendation: B**).

Adjuvant Chemotherapy

Conclusion

- Adjuvant chemotherapy is under debate. Neither randomized trials nor a meta-analysis have provided sufficient data to support the routine use of adjuvant chemotherapy (**Level of evidence: 1a**).

Recommendation

- Adjuvant chemotherapy is advised within clinical trials, but not for routine use because it has not been studied sufficiently (**Grade of recommendation: A**).

Metastatic Disease

Conclusions

- Urothelial carcinoma is a chemosensitive tumour.
- Performance status and the presence or absence of visceral metastases are independent prognostic factors for survival. These factors are at least as important as the type of chemotherapy administered (**Level of evidence: 3**).
- Cisplatin-containing combination chemotherapy is able to achieve a median survival of up to 14 months, with long-term disease-free survival reported in about 15% of patients with nodal disease and good PS (**Level of evidence: 1b**).
- Single-agent chemotherapy provides low response rates of usually short duration (**Level of evidence: 2a**).
- Carboplatin-combination chemotherapy is less effective than cisplatin-based chemotherapy in terms of (complete response) CR and survival (**Level of evidence: 2a**).
- Non-platinum combination chemotherapy has produced substantial responses in first- and second-line use, but has not been tested against standard

chemotherapy in fit patients or in a purely unfit patient group (**Level of evidence: 2a**).
- To date, there is no defined standard chemotherapy for 'unfit' patients with advanced or metastatic urothelial cancer (**Level of evidence: 2b**).
- Small-sized phase II trials provide evidence of moderate response rates for single agents or nonplatinum combinations at second-line use (**Level of evidence: 2a**).
- Post-chemotherapy surgery after a partial or complete response may contribute to long-term disease-free survival (**Level of evidence: 3**).

Recommendations

- Prognostic factors guide treatment selection (**Grade of recommendation: B**).
- First-line treatment for fit patients: use cisplatin-containing combination chemotherapy with gemcitabine plus cisplatin (GC), methotrexate/vinblastine/adriamycin/cisplatin (MVAC), preferably with granulocyte colony-stimulating factor (GCSF), or high-dose MVAC with GCSF (**Grade of recommendation: A**).
- Carboplatin and non-platinum combination chemotherapy as first-line treatment in patients fit for cisplatin is not recommended (**Grade of recommendation: B**).
- First-line treatment in patients unfit for cisplatin: use carboplatin combination chemotherapy or single agents (**Grade of recommendation: C**).
- Second-line treatment: consider single agents or paclitaxel/gemcitabine if the patient has a good PS (**Grade of recommendation: C**).

Quality of Life

Conclusions

- There is no randomized prospective health-related quality of life (HRQL) study evaluating different forms of definitive treatment for invasive bladder cancer.
- The overall HRQL after cystectomy remains good in most patients, whichever type of urinary diversion is used. Some data suggests that continent diversions produce a better HRQL (**Level of evidence: 2b**).

Recommendations

- HRQL in patients with muscle-invasive bladder cancer should be assessed using validated questionnaires (**Grade of recommendation: A**).
- Continent urinary diversions should be offered for reasons of HRQL, whenever a patient's age, personality, coping ability and tumour variables are suitable (**Grade of recommendation: C**).

Follow-Up

Conclusions and Recommendations According to Condition

Condition	Conclusion or Recommendation	Level of Evidence or Grade of Recommendation
Secondary urethral tumour	Staging and treatment should be done as for primary urethral tumour	**3**
	For non-invasive tumour, local organ conservative treatment is advised	**C**
	In isolated invasive disease, a urethrectomy should be performed	**B**
	Urethral washes and cytology are not recommended for follow-up	**A**
Pelvic recurrence	The prognosis is poor Treatment should be individualized depending on the local extent and symptoms	**2b**
	Radiotherapy, chemotherapy and possibly surgery are options for treatment, either alone or in combination	**C**
Upper urinary tract recurrence	Specific upper urinary tract imaging is only indicated in case of clinical symptoms; radical nephroureterectomy can provide prolonged survival	**B**

General Recommendations for Follow-Up

This advice for follow-up is entirely based on expert opinion. General remarks are that follow-up should be dependent on the stage of the initial tumour after cystectomy. This means that the higher the initial tumour stage, the larger the chance for subsequent tumour recurrence. Non-oncological follow-up, for example monitoring of kidney function, seems indicated lifelong. After 5 years of follow-up, oncological surveillance may be stopped to be continued by functional surveillance.

At every visit, the following should be performed:

- History
- Physical examination
- Bone scan only when indicated

Definitions:

Levels of Evidence

1a Evidence obtained from meta-analysis of randomized trials

1b Evidence obtained from at least one randomized trial

2a Evidence obtained from one well-designed controlled study without randomization

2b Evidence obtained from at least one other type of well-designed quasi-experimental study

3 Evidence obtained from well-designed non-experimental studies, such as comparative studies, correlation studies and case reports

4 Evidence obtained from expert committee reports or opinions or clinical experience of respected authorities

Grades of Recommendation

A. Based on clinical studies of good quality and consistency addressing the specific recommendations and including at least one randomized trial
B. Based on well-conducted clinical studies, but without randomized clinical trials
C. Made despite the absence of directly applicable clinical studies of good quality

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate diagnosis and management of muscle invasive and metastatic bladder cancer

POTENTIAL HARMS

- For clinical staging with computed tomography (CT) or magnetic resonance imaging (MRI), over- and under-staging is likely to happen with a staging accuracy of only 70%. Overtreatment is the possible negative consequence.
- There is as yet no conclusive evidence that delayed cystectomy might compromise outcome.
- Side effects of chemotherapy might affect outcome of surgery and type of urinary diversion.
- Complications, including death, associated with surgical procedures
- Toxicity of chemotherapy and radiotherapy

CONTRAINDICATIONS

CONTRAINDICATIONS

Debilitating neurological and psychiatric illnesses, limited life expectancy, and impaired liver or renal function as well as transitional cell carcinoma of the urethral margin or other surgical margins are contraindications to more complex forms of urinary diversion. Relative contraindications specific for an orthotopic neobladder are high-dose preoperative radiation therapy, complex urethral stricture disease and severe urethral sphincter related incontinence.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The purpose of this text is not to be proscriptive in the way a clinician should treat a patient but rather to provide access to the best contemporaneous consensus view on the most appropriate management currently available. European Association of Urology (EAU) guidelines are not meant to be legal documents but are produced with the ultimate aim to help urologists with their day-to-day practice.
- The EAU believes that producing validated best practice in the field of urology is a very powerful and efficient tool in improving patient care. It is, however, the expertise of the clinician which should determine the needs of their patients. Individual patients may require individualized approaches which take into account all circumstances and treatment decisions often have to be made on a case-by-case basis.
- There is clearly a need for continuous re-evaluation of the information presented in the current guideline by an expert panel. It has to be emphasized that the current guideline contains information for the treatment of an individual patient according to a standardized approach. The information should be considered as providing recommendations without legal implications.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The European Association of Urology (EAU) Guidelines long version (containing all 19 guidelines) is reprinted annually in one book. Each text is dated. This means that if the latest edition of the book is read, one will know that this is the most updated version available. The same text is also made available on a CD (with hyperlinks to PubMed for most references) and posted on the EAU websites Uroweb and Urosource (www.uroweb.org/professional-resources/guidelines/ & http://www.urosource.com/diseases/).

Condensed pocket versions, containing mainly flow-charts and summaries, are also printed annually. All these publications are distributed free of charge to all (more than 10,000) members of the Association. Abridged versions of the guidelines are published in European Urology as original papers. Furthermore,

many important websites list links to the relevant EAU guidelines sections on the association websites and all, or individual, guidelines have been translated to some 15 languages.

IMPLEMENTATION TOOLS

Pocket Guide/Reference Cards

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

End of Life Care
Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Stenzl A, Cowan NC, De Santis M, Jakse G, Kuczyk M, Merseburger AS, Ribal MJ, Sherif A, Witjes JA. Guidelines on bladder cancer: muscle-invasive and metastatic. Arnhem, The Netherlands: European Association of Urology (EAU); 2008 Mar. 60 p. [366 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2008 Mar

GUIDELINE DEVELOPER(S)

European Association of Urology - Medical Specialty Society

SOURCE(S) OF FUNDING

European Association of Urology

GUIDELINE COMMITTEE

Muscle-Invasive and Metastatic Bladder Cancer Guidelines Writing Panel

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

All members of the Muscle-Invasive and Metastatic Bladder Cancer guidelines writing panel have provided disclosure statements of all relationships which they have and which may be perceived as a potential source of conflict of interest. The information is kept on file in the European Association of Urology (EAU) database. This guidelines document was developed with the financial support of the EAU. No external sources of funding and support have been involved. The EAU is a non-profit organisation and funding is limited to administrative assistance and travel and meeting expenses. No honoraria or other reimbursements have been provided.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the European Association of Urology Web site.

Print copies: Available from the European Association of Urology, PO Box 30016, NL-6803, AA ARNHEM, The Netherlands.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- EAU guidelines office template. Arnhem, The Netherlands: European Association of Urology (EAU); 2007. 4 p.
- The European Association of Urology (EAU) guidelines methodology: a critical evaluation. Arnhem, The Netherlands: European Association of Urology (EAU); 18 p.

The following is also available:

- Muscle-invasive and metastatic bladder cancer. 2008, Ultra short pocket guidelines. Arnhem, The Netherlands: European Association of Urology (EAU); 2008 Mar. 13 p.

Print copies: Available from the European Association of Urology, PO Box 30016, NL-6803, AA ARNHEM, The Netherlands.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on July 2, 2008. The information was verified by the guideline developer on August 29, 2008.

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